Cigna Dental Medicare Advantage

Cigna Dental Medicare Advantage Allowance Network: Network Participation Form

Please indicate below if you wish to Opt-In or Opt-Out by checking the applicable box below.

☐ I would like to opt-in to the Cigna Allowance Medicare Advantage Network.

☐ I would like to opt-out of the Cigna Allowance Medicare Advantage Network.

Dentist Name: ____

Taxpayer Identification Number: ______________________________

Dental Office Name: _______________________________________

Address: ____

City:______________________State:________ Zip: _______________

Dental Office Phone Number: (____) ______________ Date: ______________

Dentist Signature: ____

Please email or fax this form to:

Email: DentalMMNetwork@Cigna.com

Fax: 860.507.8618

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